

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/19/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155458</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>11/13/2015</b>	
NAME OF PROVIDER OR SUPPLIER  <b>HIGHLAND NURSING AND REHABILITATION CENTER</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>9630 FIFTH ST</b> <b>HIGHLAND, IN 46322</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	<p>INITIAL COMMENTS</p> <p>This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaints IN00184851 and IN00185260 completed on October 27, 2015.</p> <p>This visit was in conjunction with a PSR to the Investigation of Complaint IN00183022 completed on September 24, 2015.</p> <p>This visit was in conjunction with the PSR to the PSR completed on September 24, 2015 to the Recertification and State Licensure Survey completed on August 7, 2015.</p> <p>Complaint IN00184851-Corrected Complaint IN00185260-Corrected</p> <p>Survey date: November 13, 2015</p> <p>Facility number: 000367 Provider number: 155458 AIM number: 100289280</p> <p>Census bed type: SNF/NF: 26 Total: 26</p> <p>Census payor type: Medicare: 4 Medicaid: 15 Other: 7 Total: 26</p> <p>Sample: 8</p> <p>Highland Nursing and Rehabilitation Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the</p>			{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 000}	Continued From page 1 PSR to the Investigation of Complaints IN00184851 and IN00185260.  Quality review completed by 26143, on November 18, 2105.	{F 000}			